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PSYCHIATRIC PATIENT HISTORY TAKING AND NOMENCLATURE,(U)
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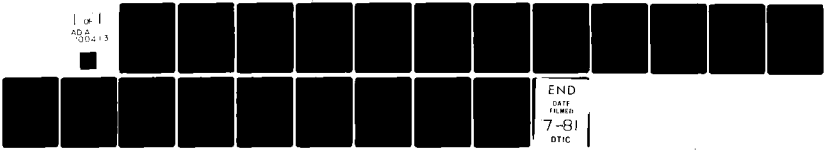


PSYCHIATRIC PATIENT HISTORY TAKING

AND

NOMENCLATURE

COL Franklin D. Jones, MD
Psychiatry and Neurology Consultant
Office of The Surgeon General of the Army
Pentagon 2D520, DASG-PSC-F
Washington, DC 20310

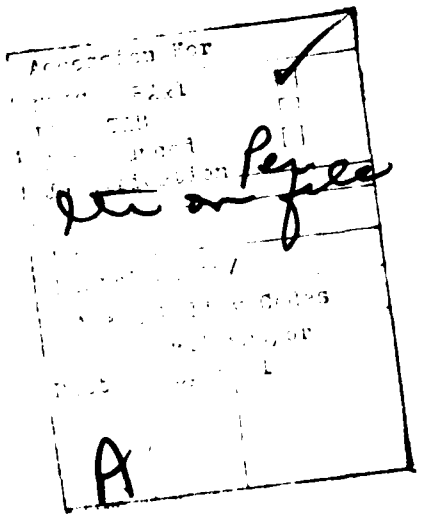
ABSTRACT

PSYCHIATRIC PATIENT HISTORY TAKING

AND NOMENCLATURE

FRANKLIN DEL JONES, M.D.
COLONEL, MEDICAL CORPS
PSYCHIATRY AND NEUROLOGY CONSULTANT
PENTAGON 2D520
HEADQUARTERS DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
WASHINGTON, D.C. 20310

THIS 20 PAGE MONOGRAPH GIVES AN INTRODUCTION TO PSYCHIATRY HISTORY TAKING PARTICULARLY RELEVANT TO THE MILITARY PATIENT. IT ALSO EXPLORES THE TRIPARTITE MEDICAL MODEL FOR UNDERSTANDING PSYCHOPATHOLOGY AND DISCUSSES ITS RELEVANCE TO CLINICAL PSYCHIATRIC DIAGNOSIS.



PSYCHIATRIC PATIENT HISTORY TAKING AND NOMENCLATURE

Franklin Del Jones, COL, MC

INTRODUCTION

You may have wondered why we included together the supposedly disparate elements of a case study, history and nomenclature. Well, they are not disparate at all. I want this to be very clear, for it touches on a fundamental principle in evaluating patients. A patient's mental illness can only be understood by evaluating the social context of his illness and his own personality substrate. When these elements, which we may roughly discover in evaluating the chief complaints and developmental history respectively, are carefully examined, a pattern will usually emerge. That pattern will point toward a categorization of the patient. That categorization is a diagnosis.

We psychiatrists assume that behavior is lawful, that it follows rules. When we see bizarre or apparently irrational conduct we must recognize that the rules are not being violated but that they may be complex. Ullmann and Krasner point out that the individual is always responding to the "demand characteristics" of a situation as he perceives them. His perceptions may, of course, be inaccurate. In summary, all behavior has meaning. It is our task to try to understand why this person is having these symptoms at this time.

It is essential that the overall longitudinal pattern of behavior be given due weight in arriving at a diagnosis. Every one of us has experienced significant anxiety at some time such as prior to a major test. Anxiety is a symptom of mental distress. Behaviorists think it is a complex behavior usually learned discriminatively (i.e., in response to specific cues), while some analysts conceive of it as central to all behavior and postulate many normal, neurotic and psychotic "defense mechanisms" for dealing with it. It is doubtful that any student of human psychology would think of the person in this example of a test-taker as suffering from a mental illness. But this example is hardly different except perhaps in degree from what we observe frequently in the Army.

A young soldier is completing infantry training and is worrying over his assignment. Since one third of the Army is overseas, he has a good chance of being assigned to West Germany or the Republic of Korea, which would separate him from his fiancee, a young woman who has shown a proclivity to find replacements for missing boyfriends. He begins to experience uneasiness and since our system rewards a soldier for going on sick call by excusing him from work, he goes to the new dispensary physician complaining of tachycardia and sweating palms. He neglects to mention his impending assignment. The dispensary physician does a thorough cardiac evaluation, asking about chest pain, finds nothing physically wrong with him, makes a diagnosis of anxiety reaction and gives him Valium. The soldier feels better which reinforces him for coming to the dispensary. He comes again and again. It's worth it to escape K.P. By now the physician is a bit angry and somewhat suspicious; however, the symptoms seem real enough and in fact they are more prominent than before. He decides to send him to see the psychiatrist. It takes about a week to get seen and in the interim the soldier's orders come down for Fort Polk, Louisiana. He still keeps the appointment (after all, it's another day off kitchen police) and duly describes his symptoms--which now include intermittent chest pain as a major complaint--to

the psychiatrist who has been around a while and asks him whether he's going overseas, having trouble with his girl or 1st Sgt., etc. He truthfully answers in the negative and the psychiatrist concludes that he is experiencing chronic anxiety without any obvious cause, i.e., chronic anxiety reaction.

Does this man have a neurosis? The answer may be debatable at this point, but one thing is quite predictable; when he does get orders to overseas or doesn't want to go out into the boon docks on a field trip or has a hassle with the 1st SGT. for "goldbricking" or "sick-book riding," his anxiety symptoms are going to blossom forth in luxuriant profusion.

Let us examine another aspect of history taking, the reason for the evaluation. Our set will change markedly when we realize we are evaluating a man for competency to stand trial or mental responsibility for alleged criminal activities. We must, however, be as objective with this person as we must be with a soldier whose motives for seeing a physician are considered more legitimate, i.e., for help with physical or emotional suffering. In neither case can mental illness or normalcy be ruled in or out without careful evaluation.

As an aside I want you to remember that in the Army as in many states there is no privileged communication. Thus you may be sworn by a court and ordered to divulge information obtained from a patient. Failure to do so may result in charges of contempt of court. Therefore to protect the patient and yourself, you should always make sure he understands his rights under Article 31, Manual for Courts Martial, when a question of criminal activity arises.

PRESENTING COMPLAINTS

It is important to listen to and record what bothers the patient, not you. For example, a patient may have a chief complaint of insommia. In obtaining the details you may also discover that he has not had sexual intercourse for 5 years and that he takes a bath 5 times a day to escape "pollution." If you list decreased libido and bathing ritual as "complaints," you are mistaken. The presenting complaints are what the patient sees as the problem. They are "where it hurts." Treating the chief complaints may not solve his problems but failing to give them due consideration and management will probably make him label you with an epithet if not something less kind.

PRESENT ILLNESS

The presenting complaints will give you some hints as to which areas to explore first. Essentially you will be doing what researchers call "event sampling." That is, you are trying to place an event, the symptom, into some context which will make sense to you. The persons who make a living by event sampling and recording, newspaper reporters, have what might be called the dictum of interrogatives. They do not feel satisfied unless they have answered the questions: What, Who, When, Where, How, Why? Let's apply this to the patient above:

What - insomnia

Who - the patient

When - evening and early AM

Where - at home

How - ruminating in evening, anxious, awakens to slight noises, cannot fall asleep.

Why - this is often unknown to patient and may be labelled "insight" if known.

As I noted, the presenting complaints will suggest areas of further exploration. For example, a complaint of insomnia will suggest depression though many other conditions including manic states, anxiety states, and overuse of coffee also produce this symptom. One might then ask questions in a non-leading manner to answer the question of depression. A neutral question about other vegetative functions such as change in appetite or weight and change in bowel movements might be asked. Finally the patient's suicidal potential should be assessed. This can be accomplished by asking about prior attempts, whether the person has actually formulated a plan, and assessing what supports he has to prevent him from suicide (wife, children, job, religion, etc.).

Thus, you see, the placid exercise of history taking quickly moves into an arena of action. If the patient leads you to believe he may harm himself or others, you are morally, and in some jurisdictions legally, bound to intervene, perhaps by forcible hospitalization.

Although it is probably wrong to assume that psychiatric conditions are diseases, it is true that symptom clusters often occur producing psychiatirc "syndromes." The term "disease" suggests a clear etiologic agent, reproducible clinical course, preferred treatment method and prognosis. It is doubtful that psychiatric entities other than a few neurological conditions truly show any of these characteristics.

To get back to the point, you will learn to associate certain groupings of symptoms into clinical syndromes. You will further learn that individuals who exhibit some characteristic, long-standing patterns of behavior (my definition of personality) will tend to exhibit symptoms of some syndromes more frequently than other personality types. The obsessive-compulsive may be prone to depression, the cyclothymic to hypomanic episodes, the schizoid supposedly to schizophrenia, the hysterical to conversion reactions, and the paranoid to persecutory delusions.

I think it's fair to say that everyone has a basic personality. A note about the personality should be made in the present illness. It will help in evaluating any psychiatric condition. You may quibble with me and ask how the personality matters, in, say, organic conditions. Even here it is of prime significance. Let us consider a condition of clearly organic etiology, say a chronic brain syndrome due to a stroke from occlusion of a cerebral artery. Let us exclude from consideration for the moment the hypertensive, possibly obese, tense, personality who may be prone to stroke. Let us assume a stroke in an older person who did not smoke, drink excessively or otherwise invite cardiovascular disease. If that person had a basically hysterical personality, the additional disorganization may be devastating while an obsessive-complusive,

orderly personality may simply rely on routines, rituals and other aids developed over time and hardly notice the effects of an additional encumbrance such as a faulty memory. On the other hand a severely obsessional personality may develop a severe neurotic response to a minor disability (limiting his striving for mastery) which a hysterical personality would hardly notice.

Prior psychiatric illnesses should be mentioned in the present illness even though they are explained elsewhere.

In summary, then, in the present illness you will include a reference to basic personality, a detailed description of presenting complaints and related behavior which you feel is pertinent. These latter will point toward a psychiatric syndrome and may be of some prognostic value. You will have obtained the history without suggesting a further progression of symptoms; that is, without asking leading questions, and you will have taken into account the set in which the symptoms occur.

You should also make a note as to the source of your information and an estimate of its reliability. If you write derogatory material, try to place it in quotes and note the source. You may thus avoid a libel suit. Remember that except in extraordinary cases, the patient must be given access to his records.

FAMILY AND SOCIAL HISTROY

I like to study the family and social history in a chronological fashion somewhat akin to what Adolph Meyer termed "The Life Chart." Meyer would place a date on one side, the age on the other, and biological systems in the middle. He would then go, year by year, through the patient's life and to either side he would catalogue significant biological and sociological events:

	AGE Mental/Neuro/C-V/Resp/G-I/G-U/Musc-Skel	YEAR	
Bronchitis	0	1934	
(sep. from M.)	1----------*	1935	During Depression
	2	1936	
	3	1937	
	4	1938	
	5	1939	
	6	1940	
	7	1941	WWII(Father absent)
	8	1942	
	9	1943	
	10	1944	
	11	1945	
Puberty	12----------*	1946	
	13	1947	
	14	1948	
Broken Arm(scar)	15----------*	1949	
	16	1950	
	17	1951	
	18	1952	Korean War(drafted)
	19	1953	
	20	1954	
Duodenal Ulcer	21----------*	1955	
	22	1956	
	23	1957	
	24	1958	
	25	1959	
	26	1960	
	27	1961	
	28	1962	
	29	1963	
	30	1964	
	31	1965	
	32	1966	
	33	1967	Vietnam tour
	34	1968	(sep. from wife)
Depressive	35----*	1969	
Neurosis	36	1970	

Whatever method is used, certain significant life situations should be recorded:

Birth. The patient may know whether he was a "blue baby," premature, prone to illness or other data. This may help in assessing retardation, probability of hyperkinetic syndrome, learning disability and even schizophrenia. Premature children have been found more prone to schizophrenia as well as these other entities mentioned.

An attitude about the birth may be inferred if the patient does not know the parental attitudes. For example, if the patient is 19 and has older siblings 28, 36, and 34, one may wonder about an "accident" and an unwanted child.

Sibling order should also be recorded since studies have shown certain traits and personalities more frequent in certain sibling orders. For example, the youngest son of an indulgent mother may be prone to being dependent, jealous and passive. Alfred Adler developed a whole theory of psychology based on sibling order.

Milestones. Developmental milestones may be obtained from a mother but they are quite likely to be inaccurate. When accurate, these can prove most important in diagnosing developmental disorders such as mental retardation and infantile autism. Age at turning over, crawling, standing and walking with help precede walking alone which most children can do by age 14 months. Babbling, saying a single word and finally saying a simple sentence will occur by about age two years.

Parents. A statement of the patient's evaluation of his parents should be included. Often the way a patient chooses to respond to this type of question will tell more about him than about them. Contrast the reply of a schizophrenic soldier who stated, "Mother was 5'3", a bit overweight but with good looks" with that of a mildly hysterical young man who stated, "Why, she was a mother!"

Usually a patient can state that one parent favored him or he may deny this claiming a strict democracy of feeling on the part of the parents. Either answer may reflect the patient's feeling of what a parent should be like.

-An estimate of the socioeconomic status of the patient should be made. This may be inferred from the educational level of parents, occupation of father, whether they own a car, own or rent a home, etc. (Reference - Hollingshead and Redlich - Social Class and Mental Illness).

-The attitude of the parents toward each other as reflected in arguments, absolute absence of arguments, separations, divorces, etc. should be ascertained. Terms such as "pseudomutuality" (hostile dependent), "family skew" (one dominant parent), and "family schism" (open warfare between parents) have been used to characterize families of disturbed patients.

-Relationships with siblings and peers should also be explored. According to Harry Stack Sullivan, a paucity of significant interpersonal relationships points toward schizophrenia.

School. For most children school is the first extra-family socialization

experience. First encounters with school should be evaluated. For example, a child who displays school phobia will probably have further troubles.

-The importance of failed courses and repeated grades is obvious in brain damage or retardation. Similarly a pattern of truancy or clashes with authority will give clues to later personality development. One finding which seems overly common in the mentally ill is good progression in school and then for no apparent reason decline in performance. If this occurs at puberty it may indicate schizophrenia or drug abuse. Impulsive quitting of school just prior to graduation is another indicator of more severe pathology.

Neuropathic traits such as enuresis, encopresis (soiling), thumb sucking, pavor nocturna (nightmares), stuttering, etc. should be recorded not as pathognomonic but as indicative of a disturbed home situation.

Delinquency including running away from home, petty thefy, property damage, "joy riding," and criminal record of any kind should be specifically asked about.

Sexual Life. A candid request for information on the patient's sex life should be made. Response of the patient to puberty, masturbation, dating habits, sexual relations (hetero- and homo-) should be noted. Don't expect completely honest answers, however. One case I recall was of a young draftee in basic training who was the only one to raise his hand when the platoon sergeant asked all masturbators to raise their hands. You guessed it. He was schizophrenic. The parental attitude toward sex should also be recorded.

Religion. One step away from sex may be religion in some patients. Religious denomination, attendance at services, etc. should be noted. It is interesting that schizophrenics with religious delusions often were not religious prior to their illnesses.

Drug Experiences. Alcoholism probably represents the number one mental health and possibly number one physical health problem in the Army and possibly in the nation. It is an illness which is preventable and treatable but usually does not get prevented or treated. Look carefully at the patient who comes in with "a cold" or gastrointestinal complaints on Mondays. Also look for the patient with repeated gastritis or a single attack of pancreatitis. In our soldier population use of marijuana a few times experimentally is probably "normal." Other drugs such as sniffing glue or gasoline, use of LSD, PCP, etc. must be explored. I examined a woman who exhibited almost classic symptoms of paranoid schizophrenia but was on amphetamines. Clues consisted of history of weight loss, insomnia and tachycardia, and on mental status exam she could repeat 8 digits forward but only 3 backward. Phencyclidine (PCP) also can produce a psychosis mimicking schizophrenia and this is often associated with violence.

Work History Difficulty in keeping a job, nomadism, decreased productivity, lack of job satisfaction are significant and should be recorded. If the patient is in the Army, one should put down where he had basic training, AIT (advanced individual training), other schools, 1st and subsequent assignments, whether in combat or a combat zone, whether he had good conduct medals, etc. Also find out if he has been AWOL, punished with Articles 15 or Courts Martial, and the punishment.

Army Records

-201 File - Personnel Record. This may be available. It contains efficiency reports, orders, records of accomplishments and punishments, etc.

-Form 600 - Health Record. The Army does not in most cases have family doctors who can remember everything about a patient; however, the next best thing is a record of all treatment the patient has received. This is in the Health Record. It also has entrance and annual physical exams and histories. On the back of the entrance P.E. prior to 1980 will be a cryptic message. For example, 7C-27-IV. This is the AFQT or rather a part of it. The 27 indicates the soldier scored in the lower 27% of soldiers taking the test. The IV indicates he can be drafted in time of war or national emergency. The 7C is probably his areas of highest aptitudes. There is also a record of the patient's assignments on the inside cover of the Health Record.

Past Medical History should be complete even for insignificant illnesses if possibly psychically traumatic, as for example, hernia repairs in oedipal-stage boys. Also a hospitalization and separation from the mother early in life may produce lasting scars and contribute to homesickness (frequent complaint in basic trainees) or separation anxiety.

I have already mentioned in passing prior psychiatric treatment. This should be documented in detail as to dates, length of treatment, inpatient or outpatient, type of therapy including ECT, drugs, psychotherapy, highlights of symptoms, presence or absence of psychosis, external precipitating events, etc. Patients who responded to a particular medication in the past are likely to respond again. Also they are likely to respond to medications which relatives responded to, especially lithium, antidepressants and neuroleptics.

Diagnostic Classification: Tripartite Model of Illness

As humans we are a kind of unholy trinity. We have a biological endowment, a social (cultural, interpersonal) endowment and we have the peculiar endowment of learning from our own experiences. Something can go wrong in any of these areas and to more or less degree all three will be influenced by that misadventure. Thus all illness can be considered as having these elements in varying proportions:

1) Organic
2) Interpersonal (social, cultural)
3) Intrapsychic (personal)

Most illnesses treated by non-psychiatric physicians predominate in organic elements; trauma, infection, metabolic, etc. Even these disorders will have interpersonal and intrapsychic elements. For example, was the trauma self-inflicted? Is the person "accident prone?" Is the person one who as a "workaholic" gets sick only during vacation? Strong psychological stress factors have been identified in asthma, doudenal ulcer, and other so-called "psychosomatic" illnesses. Even diabetes can be greatly influenced by emotional factors.

Mental disorders can be categorized according to the predominance of one or another of these elements; however, it is often most difficult to separate the three factors, especially the interpersonal and intrapsychic.

Tripartite Division of Psychiatric Disorder (examples)

1. Predominance of organic factors

   Organic brain syndromes - pre-senile and senile dementias
   - toxic, infectious, metabolic
   - Huntington's Chorea, epilepsy, etc.

2. Predominance of interpersonal factors

   Transient situational disorder
   Marital maladjustment
   Personality disorders

3. Predominance of intrapsychic factors

   Psychoneuroses - phobic, anxiety, obsessional, hysteria, etc.
   Perversions - especially those with strong fantasy elements

4. Strong elements of all three

   Schizophrenia
   Endogenous depressions
   Psychosomatic diseases

In individual disorders one or two or all three of these elements may be most prominent in the disordered behavior which we are observing; however, all three usually play a role.

Unfortunately the tripartite model of illness is not useful in classifying patients for clinical purposes since it depends on theoretical assumptions rather than presenting signs and symptoms.

The current diagnostic nomenclature, DSMIII (Diagnostic and Statistical Manual, Third Edition) was a gradual accretion of theoretical and clinical considerations. In part it is based on a nomenclature which grew out of military experiences in World War II.

Diagnostic Nomenclature - History

The oldest scientific nomenclature is probably that of Hippocrates in the Third Century BC. Hippocrates, with his humoral theory of disease, described mania, melancholia, hysteria, paranoia, hypochondriasis, epilepsy, and organic brain diseases. He attributed them to disturbances of four humors:

1) Black Bile - (earth) - melancholic personality
2) Blood - (air) - sanguine personality
3) Yellow Bile - (fire) - choleric personality
4) Phlegm - (water) - phlegmatic personality

The 1840 Decennial Census in the USA was the first to collect statistics on the mentally ill. The idiotic and insane were classed together. In 1850 the mentally ill were classed separately from idiotic, but not classified further. During the Civil War, Army Physicians made diagnoses such as "drunkenness" and "nostalgia," conditions we still see. The 1880 Census was the first attempt to classify the type of mental disorder. An 1888 comment from the Census Bureau indicates some of the same problems we face today:

> "Some Classifactions are based upon symptoms and some upon physical causes; others are a mixture of the two; and still others take into account the complications of insanity."

A broad categorization was chosen as follows:

Epilepsy
Mania
Melancholia
Monomania
General paresis
Dementia
Dipsomania

This classification was used in the 1890 census then discarded. In 1893 the ICD ("Bertillon Classification") was adopted by the International Statistical Institute in Paris. It had begun in 1853 with the gradual development of an International List of Causes of Death (ICD). The 1940 List contained one category with four subdivisions devoted to mental disorders:

84. Mental Disorders and Deficiency
(excluding general paralysis of the insane)

a. Mental deficiency
b. Schizophrenia (dementia praecox)
c. Manic-depressive psychosis
d. Other mental disorders

Also included under other categories were:

30.b General paralysis of the insane
77 Chronic or actual alcoholism
162.b Senility and senile dementia

by the turn of the 20th Century the hereditary degeneration view of all psychiatric disorder had begun to give way to psychological explanations of mental illness; nevertheless, this either/or categorization also has weaknesses.

Despite the psychobiological view of Adolph Meyer, from about 1900 to 1952 (DSM I published) all psychiatric disorders were divided into two great categories, organic and functional. Unfortunately, all kinds of ambiguities arose. Epilepsy which was idiopathic showed no evidence of structural damage in the brain but was considered organic, not functional. Schizophrenia, likewise without structural brain damage was considered functional but has strong genetic elements. Mental deficiency was considered organic; however, recent studies have revealed so-called "social deprivation mental deficiency" which may be prevented by programs aimed at providing a stimulating intellectual environment to infants and small children.

In 1923 a special census of patients in mental hospitals was carried out by the APA (American Medico-Psychological Association, now called American Psychiatric Association) and the National Committee for Mental Hygiene under Clifford Beers' leadership. The APA used this classification until 1934 when the first edition of the Standard Nomenclature of Diseases came out (Jordan, 1933). The SND was used until publication of DSMI. In 1948 the WHO International Classification of Diseases was published and in 1952 partly as an outgrowth of it DSMI was published.

Army Medical Nomenclature

The Army gradually developed its own nomenclature partly on the basis of its internal needs. If you get a chance to read COL Bill Anderson's Abbreviated History of Military Psychiatry, you will find some of the earliest diagnoses reflected problems of the times. For example, "drunkenness" and "nostalgia" were clinical entities described by Civil War Surgeons which still plague us today.

Until the Army got into the business of giving medical disability pensions on a large scale after WW II, diagnosis wasn't all that important. Whatever his diagnosis, if he didn't have a bad discharge, a soldier could get compensation from the VA. When the Army began giving medical pensions, for a short period of time anyone who was medically disabled automatically got 75% of base pay for

life. You can bet there weren't many called psychiatrically disabled. Finally the Army got into the business of giving pensions in a big way and had to decide the merits of various clinical conditions. It decided that some guys weren't mentally ill but couldn't fit into the Army. Thus were the character and behavior disorders delineated.

The old diagnosis of Constitutional Psychopathic Inferior was expanded and made less derogatory by dividing it into various immaturity reactions and personality disorders. Colonel, later General, William Menninger took the lead in this revision. Perhaps another consideration in addition to a more therapeutic attitude was the discovery that in adverse circumstances such as combat or POW camps these "constitutional inferiors" survived better than their cohorts.

From the mid-Forties to the early Sixties due to the influence of Adolf Meyer and his students everything was called a "reaction": schizophrenic reaction, emotional instability reaction, neurotic depressive reaction, etc. Exceptions to this were the personality disorders which were considered to have developed in early childhood. This is still the justification for calling the Character and Behavior Disorder "EPTS" (existed prior to service).

Just as psychiatric opinion was divided in regard to levels of mental responsibility in neuroses, so was that of the Army. The Army finally decided these were compensable medical illnesses but the amount of compensation would be less. Organic and psychotic conditions were considered fully legitimate and were compensated just as any other medical disease.

This bring us roughly up to AR 40-401, the Armed Forces Medical Diagnosis Nomenclature and Statistical Classification. This follows ICD-9 and is divided into three sections:

A. Psychoses
B. Psychoneurotic Disorders
C. Disorders of Character, Behavior and Intelligence

The organic disorders are included under each of the three sections according to symptom complex produced. For example, Brain Syndrome manifested by psychoneurosis is a grouping. Psychophysiologic reactions are listed under the psychoneurotic section. However, enuresis is listed under Immaturate Personality Disorders. You have to pick your symptom carefully. This nomenclature is now used only for the qualifying terms (degree, chronicity of illness, stress, predisposition and impairment). Otherwise DSMIII (published 1980) is used for the wording and ICD-9 for the statistical number.

DSMIII interestingly copies from the Army in including qualifying terms for "psychosocial stressors" and "highest level of adaptive functioning in the past year," roughly equivalent respectively to "stress" and "impairment" in Army nomenclature.

The following guidelines and examples for recording psychiatric diagnoses in Army facilities apply.

1. Diagnoses will continue to be numbered ordinally as currently (first diagno-

sis being reason for cause of admission); however, the appropriate axis number (I, II or III) will be placed in parentheses following the ordinal number.

Examples:

a. Case of a soldier presented for MEB:

(1) (AXIS III) 850.0 concussion syndrome, secondary to fist blow to face, acute, resolving, manifested by headache, nausea, LOD: undetermined, pending investigation.

(2) (AXIS I) 297.0 paranoid state, acute severe, manifested by fixed delusion of wife's infidelity and impaired judgment and insight; stress, minimal, routine military duty; impairment for military duty, marked, and for social and industrial adaptability, slight; LOD: yes.

(3) (AXIS I) 300.1 psychogenic amnesia, acute, severe, in remission, manifested by 15 minutes of amnesia; stress, moderate, found wife in bed with friend; predisposition, marked, see diagnosis 4; impairment for military duty and social and industrial adaptability, none, LOD: yes.

(4) (AXIS II) 301.0 paranoid personality, severe, manifested by suspiciousness, litigiousness, aggressive outburst, and impaired judgment and insight; impairment, marked for military duty, none for social and industrial adaptability; LOD: no, EPTS.

b. Case of soldier being returned to duty for administrative separation:

(1) (AXIS II) 301.7 antisocial personality, severe, manifested by history of repeated burglary and other delinquency; impairment, marked for military duty, none for social and industrial adaptability; LOD; no EPTS.

c. Case of a dependent:

(1) (AXIS I) 302.8 fetishism, mild, manifested by sexual arousal associated with kewpie dolls; impairment for social and industrial adaptability, none.

3. Psychiatric combat casualties consist of a unique group of military patients for whom the diagnosis has strong possibilities for adversely affecting recovery. The term "battle fatigue" is ideal in that it suggests a nearly normal response, is relatively non-specific in allowing for labelling of the great variety of symptom syndromes known to occur and most importantly conveys an expectancy of rapid resolution. The disadvantage is that many psychiatric casualties occur so soon in combat that fatigue cannot reasonably be presumed to be a factor. Policy will be that patients in whom fatigue can reasonably be considered a factor will continue to be diagnosed as battle fatigue while those in whom fatigue cannot be so considered will be diagnosed transient battle reaction. Both terms should be considered roughly equivalent, should be treated similarly and will be coded with ICD-9 number 308.4 (mixed disorders as reaction to stress). Avoidance of technical terms which could be regarded as diagnoses (e.g., "anxiety, conversion, paralysis," etc.) is desirable. Two examples follow:

a. Unwounded soldier presenting with tremor, tachycardia, sweating, paralysis of right arm, and glove anesthesia of right hand ten minutes after observing a friend killed in the first hour of battle:

(1) (AXIS I) 308.4 transit battle reaction manifested by numbness and weakness of right arm and hand, sweating, and rapid pulse, LOD: yes.

b. Unwounded soldier developing fatigue, tremor, tachycardia, sweating, paralysis of right arm, and glove anesthesia of right hand following 36 hours of sustained combat exposure:

(1) (AXIS I) 308.4 battle fatigue manifested by fatigue, numbness and weakness of right arm and hand, sweating and rapid pulse, LOD: yes.

4. Recording of alcohol and drug related diagnoses will be in accordance with current DOD regulations; however, AXIS I will be placed in parentheses following the ordinal number and the DSMIII diagnosis will be placed in parentheses immediately following the DOD diagnosis. An example follows of an individual with alcohol and opiate dependency:

a. (AXIS I) 3042A* single drug dependency, heroin, with alcohol dependency (alcohol dependence, continuous episodic, etc.; opioid dependence, continuous, episodic, etc.), manifested by injection of five "bags" of heroin daily and signs of tolerance and withdrawal and by repeated loss of jobs due to inebriation; LOD: not applicable.

*The numbers are in the process of revision.

Finally I want you to carry with you this idea: a diagnostic label amounts to an administrative and legal decision about a patient. Use it cautiously and in keeping with the best interests of the patient and the Army.

The following outline for psychiatric examinations was recommended in a textbook of psychiatry.

OUTLINE - NOYES-KOLB

1. Identifying date.

2. Reason for referral.

3. The problem.

4. Present illness, - onset of symptoms and character changes, social situation, changes in mood, interest, attitude, habits; significant relationships, work efficiency, memory, activity, speech, conduct, physiological indicators, social drive, patient's attitude toward illness, gains from illness.

5. Family history, - genetic, familial, economic and social forces, methods of forcing obedience, relative position and response to it, (favorite child, etc.), significant events, loss of parent or sibling, mental illness, suicide, alcoholism, delinquency, eccentricity, illegitimacy, adopted or foster child.

6. Personal history. Infancy - eating spontaneity, irritability, illness, - childhood - autonomy, repetitious dreams, enuresis, stuttering, somnambulism, nightmares, phobias, school truancy, deportment, illness -adolescence - illness, peer relations, puberty, sex exploration, idealized identification, - maturity - marriage and child rearing, work, peer authority relations, - late maturity - menopause, separation from children, retirement or death of others, recreation, avocation, alcohol, religion.

7. Personality, - social adaptability, general activity, traits, characteristics, such as indolence, industry, interests, leisure usage, alertness, preoccupation, talkativeness, taciturnity, satisfaction, dissatisfaction, emotional fluctuations, cheerfulness, light-hearted, optimistic, gloomy, pessimistic, worrisome, daring, timid, cautious, overconfidence, self-reliance, dependent, demonstrative, stolid, outgoing, shut-in, frank, reserved, reticent, bashful, at ease, aggressive, submissive, stingy, honest, deceitful, suspicious, given to misinterpretation, easily offended, slighted, resentful, hostile, cynical, blame others, argumentative, stubborn, envious, cruel, self-conscious, self-blaming, meticulous, perfectionistic, orderly, conscientious, scrupulous, boastful, overbearing, arrogant, calm, irritable, hypochondriacal, rigid, adaptable, responsible, inadequate sense of humor, daydreamer.

8. Emotionally disturbing experiences.

9. Psychiatric examination:

   A. General appearance, manner, attitude.
   B. Consciousness.
   C. Affectivity and Mood.
   D. Collation and expressivity.
   E. Associations and thought processes.
   F. Thought content and mental trend.

G. Perception.
H. Memory.
I. Fund of Information.
J. Judgment.
K. Insight.
L. Personality maturity.

References

Course outline and core reading list on psychiatric interviewing techniques:

1. Introduction to Psychiatric Interviewing.

   1) Erikson, E.H. Childhood and society, New York, N.Y.: W.W. Norton & Co., Inc. 1950, pp. 23-47, 72-108, 247-274.

   2) Fast, Julius. Body Language, New York, N.Y.: M. Evans & Co., Inc. 1970 (available in paperback).

   3) Sullivan, H.S. The Psychiatric Interview, H.S. Perry and M.L. Gawel (eds.) New York, N.Y.; W. W. Norton & Co., Inc. 1954, pp. 3-41, 128-208.

   4) Jones, F.D. Patient History Taking and Nomenclature.

2. Schizophrenia.

   1) MacKinnon, R.A. and Michels, R. The Psychiatric Interview in Clinical Practice. Philadelphia, Pa.: W.B. Saunders Co., 1971, pp. 230-258.

   2) Ullman, L.P. and Krasner, L. A psychological Approach to Abnormal Behavior. Englewood Cliffs, N.Y.: Prentice-Hall, Inc., pp. 353-376.

3. Paranoid Syndromes.

   1) Swanson, D.W., Bohnert, and Smith, J.A. The Paranoid. Boston, Mass.: Little, Brown, and Co. 1970, pp. 1-64.

   2) Ullman, L.P. and Krasner, L. A Psychological Approach to Abnormal Behavior. Englewood Cliffs, N.J.: Prentice-Hall, Inc., pp. 429-443.

4. Sociopathic Behavior.

   1) Cleckley, H. The Mask of Sanity, St. Louis, Mo.: C.V. Mosby Co., 1965, pp. 19-74.

   2) Johnson, A.M. and Szurek, S.A. "The Genesis of Antisocial Acting Out in Children and Adults" Psychoanalytic Quarterly, Vol. 21, 1952, pp. 323-343.

   3) MacKinnon, op. cit., pp. 297-338.

5. Depression.

   1) Kraepelin, E. "Depressed Stage of Maniacal-Depressive Insanity (Circular Stupor), Lecture #2 in Lectures on Clinical Psychiatry, New York, N.Y.: William Wood and Co., 1912, pp. 59-78.

   2) MacKinnon, Op. cit., pp. 174-229.

3) Storrow, H.A. "The Diagnosis of Depression" in Enelow, A.J. Depression in Medical Practice, Merck & Co., 1970, pp. 21-38.

6. Organic Brain Syndromes.

1) Freedman, A.M. and Kaplan, H.I. Comprehensive Textbook of Psychiatry. Baltimore, Md.: The Williams and Wilkins Co., 1967, pp. 706-740, 759-775.

2) Arieti, S. American Handbook of Psychiatry. New York, N.Y.: Basic Books, Inc., 1959, pp. 964-979.

3) Jones, F.D. "Historical, Clinical and Theoretical Considerations of Organic Brain Syndromes" - xerox copy.

4) MacKinnon, op. cit., pp. 339-360.

7. Obsessive-Compulsive Syndromes.

1) Reich, W. "The Compulsive Character" in Character Analysis, trans. by T.P. Wolfe, New York, N.Y.: The Noonday Press, 1949, pp. 193-200.

2) MacKinnon, op. cit., pp. 87-109.

8. Hysterical Behavior.

1) MacKinnon, op. cit., pp. 110-146.

2) Chodoff, P. and Lyons, H. "Hysteria, Hysterical Personality and the Hysterical Conversion" American J. Psychiat., Vol. 114, 1958, pp. 734-740.

9. Psychosomatic Syndromes.

1) Alexander, F.G. and Selesnick, S.T. "The Psychosomatic Approach to Medicine" in The History of Psychiatry, New York, N.Y.: Harper and Row, 1966, pp. 388-401.

2) MacKinnon, op. cit., pp. 363-373.

10. Manic Behavior.

1) Kraepelin, op. cit., pp. 59-78.

2) Freedman and Kaplan, op. cit., pp. 676-688.

11. Diagnosis

1) DSM III